LOUISIANA DEPARTMENT OF LABOR
OFFICE OF WORKERS' COMPENSATION ADMINISTRATION
POST OFFICE BOX 94040
BATON ROUGE, LA 70804-9094
(800) 201-2494

SPECIAL REIMBURSEMENT CONSIDERATION APPEAL

INSTRUCTIONS: Please provide the following information and return Parts 1 and 2 intact with the required medical records to the address shown below. Send Part 3 to the Workers' Compensation insurance carrier. Retain the last copy for your files. It should be understood that an appeal is not a guarantee of additional reimbursement.

DATE	WORKERS' COMPENSATION CARRIER NAME AND ADDRESS

HOSPITAL INFORMATION

HOSPITAL NAME			
ADDRESS	CITY, STATE, ZIP		
CONTACT PERSON	TITLE	TELEPHONE	EXT

PATIENT INFORMATION

PATIENT NAME		SOCIAL SECURITY NUMBER
EMPLOYER NAME AND ADDRESS		DATES OF SERVICE
PATIENT ADDRESS	CITY. STATE. ZIP	
DIAGNOSIS AND SURGICAL PROCEDURES		
WAS ADMISSION PRE-CERTIFIED? ☐ YES ☐ NO	IF NO, HAS OFFICE OF WORKERS' COMPENSATION BEEN NOTIFIED OF THE ADMISSION? ☐ YES ☐ NO	

MEDICAL INFORMATION

The following information **must** be submitted with and appeal for special reimbursement consideration.

- Entire medical record
- Itemization of charges
- All supporting information which could substantiate percentage of charge reimbursement.

STATE OFFICE OF WORKERS' COMPENSATION USE ONLY

SPECIAL CASE CONSIDERATION ☐ **APPROVED** ☐ **DENIED**

NAME	TITLE	REIMBURSEMENT RATE

REASON

SEND THIS FORM TO :

Louisiana Department of Labor
Office of Workers' Compensation Administration
Medical Services Section
Post Office Box 94040
Baton Rouge, LA 70804-9040